Summit Health & Wellness Center

Acupuncture & Chiropractic Integrative Clinic

HIPAA Consent

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____ give Summit Health & Wellness Center and Acupuncture & Chiropractic Integrative Clinic consent to use or disclose my protected health information to carry out my treatment, to obtain payment from my insurance company and for health care operations like quality reviews.

I have been informed that I may review Summit Health & Wellness Center and Acupuncture & Chiropractic Integrative Clinic's Notice of Privacy Practice (for a more complete description of uses and disclosures) before signing this consent.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Summit Health & Wellness Center and Acupuncture & Chiropractic Integrative Clinic is not required to agree to the request. If ACI Clinic and Wellness Center agrees to my requested restriction(s), they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Patient's or Responsible Party's Signature: _____ Date:_____

If signed by Responsible Party, please provide below information:

_____

Name (PLEASE PRINT) **Relationship to patient** **Witness**